

MONTANA NATIONAL GUARD ASSOCIATION STATE SPONSORED LIFE INSURANCE PROGRAM



SPONSORED BY:

Montana National Guard Association
 P.O. Box 2572
 Staunton, VA 24402-2572
 (800) 462-7441
 (540) 248-2527



\$1,000 of Coverage Provided to All Active Members of the Montana National Guard Plus up to \$25,000 Optional Life Insurance Benefits and Dependents Coverage.

LIFE INSURANCE BENEFITS

\$1,000, \$10,000, \$15,000, \$20,000, \$25,000

\$1,000 of group term life insurance is provided, under this program, to all active members by the Montana National Guard. In addition, \$10,000 of term life insurance may be applied for during your initial enrollment period without furnishing evidence of insurability. You must be able to satisfactorily answer just three simple health questions, and not have been previously denied coverage under this plan. Coverages in excess of \$10,000, as well as coverage applied for after your initial enrollment period are subject to evidence of insurability satisfactory to ReliaStar Life. This plan is underwritten by ReliaStar Life Insurance Company.

PLAN FEATURES

- ☆ New Simplified Issue application process
- ☆ An additional 20% benefit is provided to active members' optional coverage after one year. This additional benefit is provided by the Montana National Guard Association at no additional cost to you.
- ☆ Premiums waived for member if totally disabled, as defined in the certificate, before age 60
- ☆ Early payout for terminal illness
- ☆ Life insurance payable in event of death from any cause
- ☆ No war exclusion
- ☆ No suicide exclusion
- ☆ No aviation exclusion
- ☆ No Hazardous Duty or Civilian Occupation Restriction
- ☆ Full conversion privilege upon individual termination regardless of health

BENEFICIARY

Your primary beneficiary will be eligible for an immediate death benefit of up to \$10,000 within 24 hours of notification from the Association to ReliaStar Life Insurance Company. This benefit is designed to help with the immediate expenses surrounding the death of a member. Any death benefit payable in excess of \$10,000 will be paid upon receipt of claim forms at ReliaStar's Home Office.

INDIVIDUAL TERMINATION

Basic member coverage (\$1,000 benefit) terminates at age 60, or on the last day of the month in which the member is active in the National Guard. At insured's age 60, any optional coverage purchased (including Spouse and Spouse Dependent coverage) will be reduced by 50%, and the premium will remain the same. Optional coverage terminates at age 70.

CONTINUATION OF COVERAGE

Optional coverage may be continued after leaving the National Guard until age 70.

MEMBER COVERAGE

Coverage	Monthly Premium
\$ 10,000	\$ 3.66
\$ 15,000	\$ 5.33
\$ 20,000	\$ 7.00
\$ 25,000	\$ 8.67

LIFE INSURANCE FOR DEPENDENTS (spouse and children)

(Cannot exceed Member's Coverage)

Monthly Cost	\$ 3.33	\$ 6.66
SPOUSE Benefit	\$ 5,000	\$ 10,000
CHILDREN Benefit		
14 days to 6 months	\$ 1,000	\$ 2,000
6 months to 2 years	\$ 2,000	\$ 4,000
2 years to 3 years	\$ 4,000	\$ 8,000
3 years to 21 years*	\$ 5,000	\$ 10,000

**to age 23 if full-time student*

SPOUSE INSURANCE (spouse only)

(Total combined coverage for spouse under the Dependents option and Spouse option cannot exceed Member's Coverage)

Coverage	Monthly Premium
\$ 5,000	\$ 2.00
\$ 10,000	\$ 3.66
\$ 15,000	\$ 5.33
\$ 20,000	\$ 7.00
\$ 25,000	\$ 8.67

Coverage is subject to renewal by the Montana National Guard Association and timely premium payment. This is a paid endorsement. Rates shown are guaranteed for initial year of coverage only. A complete description of benefits and limitations of the plan will be found in the insurance policy. Policy Form LP08GP.

RELIASTAR LIFE INSURANCE COMPANY

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

OUR UNDERWRITING PROCEDURES

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

PRIVACY AND INFORMATION PRACTICES

Collecting Information

Your application is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws; the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice regarding MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Underwritten by:

**ReliaStar Life
Insurance Company**

20 Washington Avenue South
Minneapolis, Minnesota 55401
[All states except New York]

TERM INSURANCE INFORMATION

Date coverage applied for	_____ / _____ / _____
Total amount of Guard Member coverage applied for	\$ _____
Amount of Dependent coverage applied for	\$ _____
Amount of Spouse coverage applied for	\$ _____
Beneficiary designated	_____

1 TELL US ABOUT YOURSELF

YOUR NAME <i>(last, first, middle)</i>			SOCIAL SECURITY NUMBER		DATE OF BIRTH
STREET ADDRESS			RANK	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
CITY	STATE	ZIP	DAYTIME PHONE ()		NG UNIT LOCATION

2 BENEFICIARY INFORMATION

Beneficiaries may include your spouse, children, parents, charities or anyone you wish. You may list more than one beneficiary, but please list the percent each should receive. The total must equal 100 percent.

NAME	ADDRESS <i>(if known)</i>	RELATIONSHIP	PERCENT

3 GUARD MEMBER COVERAGE New Enrollment Increase in Coverage

GUARANTEED ISSUE COVERAGES <input type="checkbox"/> \$ 1,000 (NO COST TO YOU) <input type="checkbox"/> \$10,000* (\$3.66/month)	SIMPLIFIED ISSUE COVERAGES — COMPLETE SECTION 5 <input type="checkbox"/> \$15,000 (\$5.33) <input type="checkbox"/> \$20,000 (\$7.00) <input type="checkbox"/> \$25,000 (\$8.67)
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4 FAMILY COVERAGE

SPOUSE NAME <i>(last, first, middle)</i>	SPOUSE SOCIAL SECURITY NUMBER	SPOUSE DATE OF BIRTH
GUARANTEED ISSUE COVERAGES Spouse & _____ children <input type="checkbox"/> \$5,000* (\$3.33) (number of children) Spouse Only <input type="checkbox"/> \$5,000* (\$2.00)	SIMPLIFIED ISSUE COVERAGES — COMPLETE SECTION 5 Spouse & _____ children <input type="checkbox"/> \$10,000 (\$6.66) (number of children) Spouse Only <input type="checkbox"/> \$10,000 (\$3.66) <input type="checkbox"/> \$15,000 (\$5.33) <input type="checkbox"/> \$20,000 (\$7.00) <input type="checkbox"/> \$25,000 (\$8.67)	

**\$10,000 on yourself and/or \$5,000 Dependent Coverage and/or \$5,000 Spouse Coverage is a Guaranteed Issue, which means for this coverage there is no requirement for proof of insurability. If you are applying for more than Guaranteed Issue or if it is after your initial enrollment period, answer the health questions below. Application for spouse coverage also requires completion of the health questions. (Total dependent/spouse coverage cannot exceed the member's coverage.)*

5 HEALTH INFORMATION FOR SIMPLIFIED ISSUE COVERAGE

Member: Height _____ ft _____ ins Weight _____ lbs	Spouse (approx.): Height _____ ft _____ ins Weight _____ lbs
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	MEMBER		SPOUSE	
	YES	NO	YES	NO
a. Have you ever had or been treated for heart trouble, stroke, diabetes or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you ever sought help or received counseling or treatment for anxiety/depression, alcohol or drug use, or are you currently using illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "yes" to any of the questions above, please give details below and on additional sheets if needed.

NATURE OF ILLNESS, INJURY OR OPERATION	DATES(S) OF TREATMENT	REMAINING EFFECTS	NAME AND ADDRESS OF DOCTORS AND HOSPITALS

6 READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

Authorization and Acknowledgment - Please read and sign below.

For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 24 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

Any person who knowingly and with intent to defraud, submits an application or files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- If ReliaStar Life approves underwritten coverage, the effective date of the underwritten coverage will be the date on which the application and allotment form were signed.
- If ReliaStar Life denies underwritten coverage, only the guaranteed issue amount will be in effect from the date the application was signed.

YOUR SIGNATURE	DATE SIGNED	SIGNATURE OF INSURANCE REPRESENTATIVE
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